PRINTED: 08/17/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 09			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, print paric	01	COMPLETED	
		155304	A. BUILDING		07/25/2011	
			B. WING	ADDRESS OFFW STATE ZIR CORE	<u></u>	
NAME OF	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP CODE		
MATER		T. I.E.		16TH ST		
WATERS	S OF NEW CASTLE	, IHE	I NEW C	ASTLE, IN47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
	A Life Sefety Co	ode Recertification and	K0000	Preparation and/or execution	n of	
	I		KUUUU	this plan of correction in gen		
		Survey was conducted by		or this corrective action in	,	
		Department of Health in		particular, does not constitut	e an	
	accordance with	42 CFR 483.70(a).		admission or agreement by		
				facility of the facts alleged or	,	
	Survey Date: 07	7/25/11		conclusions set forth in this	.	
				statement of deficiencies. T plan of correction and specif		
	Facility Number	: 000201		corrective actions are prepar		
Provider Number: 155304				and/or executed in complian		
	AIM Number: 1			with state and federal laws.T		
	7 Mivi ivallioci.	100207710		plan of correction constitutes		
	C Mari	D Life Cafet Call		credible allegation of compli		
	1 *	Bugni, Life Safety Code		with all regulatory requireme	nts.	
	Specialist			Our date of compliance is 8/24/2011.		
				8/24/2011.		
	At this Life Safe	ty Code survey, The				
	Waters of New C	Castle was found not in				
	compliance with	Requirements for				
	1 -	Medicare/Medicaid, 42				
	1 *	3.70(a), Life Safety from				
	1	0 edition of the National				
		Association (NFPA) 101,				
		, , , , ,				
	1	e (LSC), Chapter 19,				
		Care Occupancies and				
	410 IAC 16.2.					
	The Waters of N	ew Castle was located on				
		a four story sprinklered				
	1 -	ined to be of Type I (332)				
		h a basement. The				
	facility has a fire	e alarm system with				

spaces open to the corridors. The facility LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

smoke detection in the corridors and

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TCY721

Facility ID:

000201

If continuation sheet

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED
		155304	B. WING		07/25/2011
NAME OF I	PROVIDER OR SUPPLIER		I	T ADDRESS, CITY, STATE, ZIP CODE	
WATERS	OF NEW CASTLE	THE		N 16TH ST CASTLE, IN47362	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
IAG		66 and had a census of	IAG	DEFICIENCE)	DATE
	50 at the time of				
K0025 SS=E			K0025	K 025lt is the intent of this fa to ensure smoke barriers in rooms are constructed to proat least a one half hour fire resistance rating.1. Correcting action for affected residents: All wall penetrations in the elevator landing were filled where the maintenance Supervisor.2. Residents with the potential affected: A. Maintenance Supervisor completed audit of fire/smoke walls to ensure where the maintenance of the supervisor of the supervisor ware free of opened penetrations.	ovide  ve a.  vith  Other to be  for all alls

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TCY721 Facility ID:

000201

If continuation sheet Page 2 of 12

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155304	B. WINC			07/25/2	011
			B. 11111		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				16TH ST		
WATERS	OF NEW CASTLE	, THE			ASTLE, IN47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of the smoke b				Measures to prevent reoccurence: A. Maintenanc	e	
		n approved device		Supervisor/designee will		•	
	designed for th	e specific purpose.			complete monthly audits to		
	This deficient pra	This deficient practice could affect 36			ensure fire/smoke walls are f		
	residents who reside on the 300 Hall with				from open holes/cracks as pa		
	resident rooms n	umbering room 300 to			the preventative maintenance	е	
room 356.				program.4. Monitoring of corrective action to ensure the	ie		
	Findings include	the audit results in the monthly			ıly		
	Based on observation with the maintenance supervisor on 07/25/11 at				safety meeting and in the fac		
					quarterly QA meeting.5. Dat compliance: A. 8/24/2011	e ot	
	_				compliance. A. 6/24/2011		
		levator landing room had					
		four inch penetrations in					
		d two, three inch					
	penetrations in th	ne ceiling from electrical					
	conduit and water	r piping filled with					
	expandable foam	. Based on an interview					
	-	ance supervisor on					
		5 a.m., the expandable					
	foam is not a fire						
	Toani is not a mic	racci material.					
	3.1-19(b)						
K0027 SS=E		smoke barriers have at least rotection rating or are at					
		solid bonded wood core.					
		ve plates that do not exceed					
		bottom of the door are					
		ntal sliding doors comply					
		ors are self-closing or in accordance with					
19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is							
not required. 19.3.7.5, 19.3.7.6, 19.3.7.7							
	•	ation and interview, the	K0	027	K 027It is the intent of this fa	cility	08/24/2011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETI	ED
		155304	B. WIN			07/25/201 <sup>-</sup>	1
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				16TH ST		
WATERS	OF NEW CASTLE	THE		1	ASTLE, IN47362		
					7.01EE, 1147.002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		ensure 3 of 4 sets of			to ensure smoke barrier door		
	smoke barrier doors would restrict the movement of smoke for at least 20				restrict the movement of smo for at least 20 minutes.1.	oke	
					Corrective action for affected		
	minutes. LSC 19	9.3.7.6 requires doors in			residents: a. Henry County		
		nall comply with Section			Hospital Maintenance staff m	nade	
		.1 requires doors in			adjustments to smoke barrie		
		-			doors by resident rooms 304	,	
		nall close the opening			334, and 344 to ensure comp		
		minimum clearance			door closure. 2. Other reside		
		pper operation which is			with the potential to be affect	ed:	
	defined as 1/8 inc	ch. This deficient			<ul> <li>a. Maintenance Supervisor completed audit of all smoke</li> </ul>		
	practice could af	fect all residents in the			barrier doors to ensure adeq		
	facility.				closure. No other areas of	uate	
	j				concern were identified.3.		
	Findings include	<u>.</u>			Measures to prevent		
	1 manigs merade	•			reoccurrence: a. Maintenan	ce	
	D 1 1	07/25/11 1			Supervisor/designee will		
		ations on 07/25/11 during		complete monthly audits as part			
		lity from 9:30 a.m. to			of the preventative maintena		
	2:10 p.m. with th	e maintenance			program to ensure smoke ba doors close completely.4.	mer	
	supervisor, the se	et of smoke barrier doors			Monitoring of corrective action	n to	
	by resident room	304, the set of smoke			ensure the practice will not		
	barrier doors by	resident room 334, and			recur:a. The		
	<u>-</u>	barrier doors by resident			Administrator/Designee will		
		ad a one inch gap where			review the audit results in the	,	
		• •			monthly safety meeting and a	again	
		met. This was verified			in the facility quarterly QA		
	-	ice supervisor at the time			meeting.5. Date of Compliar	nce:	
	of observations.				a. 8/24/2011		
	3.1-19(b)						

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		NSTRUCTION 01	(X3) DATE S COMPL	
		155304	B. WIN			07/25/2	011
	PROVIDER OR SUPPLIER			1000 N	DDRESS, CITY, STATE, ZIP CODE 16TH ST ASTLE, IN47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  1. Based on obset the facility failed door to 2 of 5 has laundry room and room, were providevices which we automatically cloframes. This defaffect 36 resident Hall with resident 300 to room 356.  Findings includes Based on observation at the facility failed to clope the facility failed affect 36 resident that the supervisor, the set two doors to the three hundred two each failed to clope an utility room clean utility room control of the facility failed to clope and the failed to clope and	em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches if the door are permitted.  ervation and interview, to ensure the corridor exardous areas, such as a did a combustible storage fided with self closing ould cause the doors to use and latch into the door ficient practice could the who reside on the 300 at rooms numbering room the servations on 07/25/11 during lity from 9:30 a.m. to	K	0029	It is the intent of this facility to ensure the corridor doors to hazardous areas are provided with self closing devices which cause the doors to automatic close and latch into the door frame. It is the intent of this facto ensure soiled linen recept of more than 32 gallons are located in a room with smoke resistant walls equiped with a closing door. 1. Corrective after affected residents: a. He County Hospital Maintenance staff installed self closing device 2 doors in the laundry roof ensure closure and latching doors into the door frames. The maintenance staff made adjustments to the self closing device attached to the clean room door to ensure complect closure and latching of door the door frame. b. Maintena staff installed inserts in the slinen containers used in the facility corridors limiting the internal capacity to less than eaqual to 32 gallons. 2. Other Residents with the potential in the sline containers with the potential in the series of the corridors with the series o	ed ch cally acility acility acility acility acility acility acility acility acility e a self ction enry e vices m to of HCH ang utility te into ance oiled or er	08/24/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED
		155304	B. WIN	IG		07/25/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
				1	16TH ST	
WATERS	OF NEW CASTLE,	, IHE		NEW C	ASTLE, IN47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
		istible clean linens failed			affected: a. Maintenance supervisor completed an aud	lit for
	to close and latch leaving a one inch gap between the door and frame. This was				all corridor doors to hazardou	
					areas to ensure placement o	
		aintenance supervisor at			self closing devices causing	
	the time of obser	vations.			closure and latching into doo	
					frames. No areas of concerr	1
	3.1-19(b)				noted. b. Maintenance supervisor completed an auc	lit for
					all soiled linen receptacles to	
	2. Based on obs	servation and			ensure less than or equal to	
	interview, the fa	acility failed to			gallons capacity limit is met.	3.
		ous areas in 2 of 4			Measures to prevent reoccurrence: a. Maintenan	CO
	smoke compart				supervisor/designee will do	
	storage for soi				monthly audit as part of the	
	receptacles of r				preventative maintenance	
	· ·	a 64 square foot			program of all corridor doors	
	_	ed in a room with			hazardous areas to ensure door closure and latching into door	
					frame. b. Maintenance	
		t walls equipped			supervisor/designee will do	
	with a self closi				monthly audit as part of the	
	· ·	zardous areas are			preventative maintenance program of all soiled linen ba	rrels
	I	equipped with self			located in facility corridors to	
	_	or with doors that			ensure placement of inserts.	4.
	close automatio				Monitoring of corrective action	
		e fire alarm system.			ensure the practive will not re a. Administrator/designee w	
	· ·	ractice affects all			review the audit results in the	
	residents in the	e facility.			monthly safety meeting and	<b>^</b>
	Finalina : :				quarterly in the facility QA meeting.5. Date of Compliar	nce.
	Findings includ	e.			a. 8/24/2011	
	Based on observa	ations on 07/25/11 during				
		lity from 9:30 a.m. to				
	2:10 p.m. with the maintenance supervisor, the 300 Hall corridor by					
		8, the 300 Hall corridor				
	135140111 100111 34	-, 500 Hall Collidor				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155304		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/25/2011		
	PROVIDER OR SUPPLIER			1000 N 1	DDRESS, CITY, STATE, ZIP CODE 6TH ST STLE, IN47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	by resident room 370, and the 300 Hall corridor by resident room 378 each had a soiled linen container with two, twenty four gallon soiled linen containers totaling forty eight gallons each stored in the corridor. Based on observation of the corridors on 07/25/11 at 9:45 a.m., the three soiled linen containers were stored in the corridor upon arrival at the facility and were still stored in the corridor on 07/25/11 at 1:50 p.m. Based on an interview with the maintenance supervisor on 07/25/11 at 2:00 p.m., the three forty eight gallon soiled linen containers are stored in the corridor permanently and just moved during the day while nursing staff are using them. The receptacle size was verified on the bottom of each receptacle and acknowledged by the maintenance supervisor at the time of observations.						
K0038 SS=F	readily accessible with section 7.1.	nged so that exits are at all times in accordance 19.2.1	110	020	V 02014 is the intent of this for	-11:4.	00/04/2011
	so 2 of 3 exits accessible at al requires all exit	acility failed to ess was arranged	K0	038	K 038lt is the intent of this factor ensure exit access is reading accessible at all times.1. corrective action for affected residents: a. Facility request annual life safety code waive regarding exit #3. See attachment State form 54147 Henry County Hospital maintenance to install a conditional accessible attachment countries.	t r . b.	08/24/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TCY721 Facility ID:

000201

If continuation sheet

Page 7 of 12

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155304	B. WING		07/25/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		1000 1	N 16TH ST	
	OF NEW CASTLE			CASTLE, IN47362	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
IAG			IAG	slab replacing the grassy su	
	courts, open sp			for exit #1.2. Other resident	
	· ·	exit discharge shall		the potential to be affected:	
	be of required width and size to			No residents were affected.	3.
	<sup>-</sup>	upants with a safe		Measures to prevent	200
	· ·	olic way. Where		reoccurrence: a. Maintena supervisor to audit condition	
	discharging exi	its into yards,		exit #1 to ensure accessiblit	
	across lawns, o	or on similar		part of the facility preventati	
	surfaces, in add	dition to providing		maintenance program.4.	
	the required wi	idth to allow all		Monitoring of corrective acti ensure the practice will not	II
	occupants safe	access to a public		a. Administrator/designee	
	way, such acces	ss also needs to		review the audits in the mor	•
	meet the requir	rements with		safety meeting and in the qu	uartely
	respect to mair	ntaining the means		QA meeting.5. Date of	
	I	of obstructions that		compliance: a. 8/24/2011	
	_	its use, such as			
		need for its removal			
		es or soft ground			
		eriods of rain. This			
		ce could affect all			
	residents in the				
	residents in the	tracinty.			
	Findings includ	le:			
	Based on obser	vations with the			
	maintenance su				
		ng a tour of the			
		30 a.m. to 2:10			
	p.m., the stairw				
	<sup>-</sup>				
	discharged ont				
	twenty foot cor				
	terminated onto a grassy surface,				
	and the stairwe				
	discharged ont	o a six foot by ten			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	(X2) MU A. BUILI B. WING	DING	01	(X3) DATE S COMPL 07/25/20	ETED
	PROVIDER OR SUPPLIER			1000 N 1	DDRESS, CITY, STATE, ZIP CODE 16TH ST ASTLE, IN47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0050 SS=F	onto a grassy s an interview wir supervisor and maintenance did at 12:40 p.m., exit one grassy being kept clear periods of snow grassy surfaces with water during the year, prevesurfaces being evacuation routed 3.1–19(b)  Fire drills are held varying conditions shift. The staff is fis aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement maintenancement maintenance did not a series of se	the exit three and surfaces were not r and level during v and rain and the were saturated ing a few months of inting the grassy used as an ite.  at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, the ensure fire drills were ifts over the past year. Incide affects all resident	K0	050	It is the intent of this facility to ensure fire drills are held quarterly on each shift.1. Corrective action for affected residents: a. Inservice provi to Safety/Security Director of Henry County Hospital regard requirement to hold fire drills quarterly for all shifts. Facility	ded ding	08/24/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TCY721 Facility ID:

000201 If continuation sheet Page 9 of 12

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				o1	(X3) DATE S COMPL		
		155304	A. BUILD B. WING	DING		07/25/2	
				STREET AD	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1000 N 1			
WATERS	OF NEW CASTLE	, THE		NEW CA	STLE, IN47362	-	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
ING		of the 2011 Quarterly		17kg	performs own fire drill as		DATE
		ary Report with the		secondary fire drill awareness			
		Director on 07/25/11 at			training.2. Other Residents v		
	1:15 p.m., there was no record of a fire drill conducted on the second shift for the				the potential to be affected: no residents were affected3.	а.	
					Measures to prevent		
	first quarter of th	e year 2011.			reoccurrence; a.		
Furthermore, the previous second shift				Administrator/designee will re schedule of quarterly fire drill			
	fire drill before t	he first quarter of 2011			HCH ensuring all shifts are	3 101	
	was conducted or	n 11/15/10 at 6:23 p.m.			included timely.4. Monitoring		
	and the fire drill	for the second quarter		corrective action to ensure the practice will not recur: a.			
		was conducted on Administrator/designee will re			eview		
06/30/11 at 4:40 p.m., which was a		•			the Fire Drill Summary report		
	_	ree month requirement.			HCH in the monthly safety meeting and quarterly in the		
		e drill record for second			facility QA meeting and in HC	н	
	_	irst quarter of the year			quarterly QA safety meeting.		
		d by the hospital's Safety			Date of Compliance: a.		
	Director at the tii	me of record review.			8/24/2011		
	3.1-19(b)						
K0075		sh collection receptacles do		- 1			
SS=E		(121 L) in capacity. The					
		f container capacity in a es not exceed .5 gal/sq ft					
		capacity of 32 gal (121 L) is					
		in any 64 sq ft (5.9-sq m)					
		ed linen or trash collection apacities greater than 32					
	•	eated in a room protected as					
		when not attended.					
	19.7.5.5 Based on observation	on and interview, the facility	   K00	75	K 075lt is the intent of this fac	cility	08/24/2011
	Based on observation and interview, the facility failed to ensure soiled linen containers in 2 of 4		~00	113	to ensure soiled linen contain		06/24/2011
		ceed 32 gallons. This deficient all resident in the facility.			in corridors do not exceed 32 gallons.1. Corrective action for affected residents: a.		
	Findings include:				Maintenance installed inserts	to	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 01	(X3) DATE S COMPLE 07/25/20	ETED
		155504	B. WING		07/25/20	711
	PROVIDER OR SUPPLIER OF NEW CASTLE		1000 N	ADDRESS, CITY, STATE, ZIP CODE  16TH ST  ASTLE, IN47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	a tour of the facil 2:10 p.m. with the supervisor, the 30 resident room 34 by resident room corridor by resident room corridor by resident four gallon soiled linen contains four gallon soiled forty eight gallon corridor. Based corridors on 07/2 three soiled linen in the corridor up and were still sto 07/25/11 at 1:50 interview with the on 07/25/11 at 2: eight gallon soiled stored in the corridor up and were still sto 07/25/11 at 1:50 interview with the on 07/25/11 at 2: eight gallon soiled stored in the corridor up are using them. The verified on the beand acknowledged.	ations on 07/25/11 during lity from 9:30 a.m. to be maintenance 100 Hall corridor by 18, the 300 Hall corridor 1370, and the 300 Hall cent room 378 each had a sainer with two, twenty 1 linen containers totaling as each stored in the 15/11 at 9:45 a.m., the 1 containers were stored 100 p.m. Based on an 100 p.m. Based on an 100 p.m., the three forty 100 p.m. the three forty 100 p.m. are maintenance supervisor 100 p.m., the three forty 100 p.m. are 100 p.m. and 100 p.m. the three forty 100 p.m. are 100 p.m. ar		the soiled linen containers li the internal capacity to less or eaqual to 32 gallons.2. Chesidents with the potential affected: a. Maintenance supervisor completed an aurall soiled linen containers to ensure less than or equal to gallon capacity limit is met.3 Measures to prevent reoccurrence: a. Maintenance supervisor/designee will do monthly audit of all soiled linguistrator action to ensure the practice will not recure: a. Administrator/designee will the audit results in the mont safety meeting and quarterly the facility QA meeting.5. Discompliance: a. 8/24/2011	than Other to be dit of 32 3. nce nen nent he review hly y in	
K0144 SS=F	exercised under lo month in accordar 3.4.4.1.					
	facility failed to	ation and interview, the provide 1 of 1 emergency ns with emergency	K0144	K 144It is the intent of this fa to provide emergency gener locations with emergency lighting.1. Corrective action	rator	08/24/2011

li ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155304	B. WIN	NG		07/25/2	011
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK GOTT EIEK			1	16TH ST		
	OF NEW CASTLE			NEW C	ASTLE, IN47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
		ection 7.9.2.3 requires			affected residents: a. HCH	ionev	
		rators providing power to			maintenance installed emergency lighting to emergency generator		
	emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.  NFPA 110, Section 5-3.1 requires EPS  (Emergency Power Supply) equipment location shall be provided with battery				location.2. Other Residents		
					the potential to be affected:	a.	
					No residents were affected.3	3.	
					Measures to prevent		
					reoccurrence: a. HCH maintenance to audit and tes	21	
					emergency lighting for emergency		
					generator location to meet s		
					standards.4. Monitoring of		
	powered emergency lighting. This deficient practice affects all residents in the facility.				corrective action to ensure the	ne	
					practice will not recur: a.		
	the facility.				Administrator/designee will r the audits in the monthly saf		
	Pindinoninol de				meeting and quarterly in the	ειy	
	Findings include	:			facility QA meeting.5. Date	of	
					Compliance: a. 8/24/2011		
	Based on observa						
	•	ervisor and hospital's					
	maintenance dire	ector on 07/25/11 at 12:45					
	p.m., the Detroit	diesel emergency					
	generator which	supplied emergency					
	power to the third	d floor of the hospital					
	-	metal building outside of					
		e exit. The generator					
	building lacked b	•					
	_	ng. This was verified by					
		supervisor and hospital's					
		ector at the time of					
	observation.	otor at the time of					
	ooseivalion.						
	3.1-19(b)						
	J.1 17(0)						